TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MHHS HERMANN HOSPITAL

Respondent Name
VALLEY FORGE INSURANCE CO

MFDR Tracking Number
M4-15-3701-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our firm represents the Memorial Hermann Health System (the "Hospital") in its resolution of the above referenced matter. Please consider this letter, attached DWC060 form, and enclosed records as the Hospitals' request for medical fee dispute resolution.

According to the Hospital's records, the Hospital provided the patient with the medically necessary treatment on the above dates of service, which arose from his work related injury. The Hospital's records reflect the proper reimbursement under the fee lines is 143% of the DRG. The DRG amount is $199,591.00, and 143% is $285,415.13. The Hospital received a payment in the amount of $282,266.85 from the workers compensation carrier. This underpayment leaves a balance of $3,148.28 due and owing to the Hospital. On May 6, 2015 we requested that the workers' compensation carrier reconsider the reimbursement amount and issue the additional appropriate payment, but the reconsideration was denied. Our position is the Hospital is still owed $3,148.28 under the Texas Department of Insurance's fee guidelines."

Amount in Dispute: $3,148.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier respectfully submits its DWC-60 response with supporting documentation. These records are being provided pursuant to the rules and should not be used for any other purpose … Using the figures from Exhibit A, Inpatient Pricer with DRG 3, Carrier calculated a total DRG amount of $197,389.47. Multiplying this amount by 143% results in an allowable of $282,266.94. Carrier actually paid $282,266.98 as referenced in the EORs and corresponding Pay History Screen attached hereto as Exhibit B."

Response Submitted by: Law Office of BRIAN J JUDIS 700 N PEARL SUITE 425 DALLAS TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 21, 2014 to September 05, 2014	Inpatient Hospital Services	$3,148.28	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – (16) – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 1 – (P12) – Workers' compensation jurisdictional fee schedule adjustment
   - 1 - (18) – Duplicate claim/service
   - 2 – (W3) – Request for reconsideration
   - 3 – (193) – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states:

   > The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   > (A) 143 percent; unless
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

   Review of the submitted documentation finds the requestor billed with revenue code 278 for implants however, no documentation was found to support that the facility requested separate reimbursement for implantables; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

2. Per §134.404(f)(1)(A), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 003. The services were provided at MHHS HERMANN HOSPITAL. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $197,389.47. This amount multiplied by 143% results in a MAR of $282,266.94.

3. The total allowable reimbursement for the services in dispute is $282,266.94. This amount less the amount previously paid by the insurance carrier of $282,266.85 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		8/14/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.